

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5318ADC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/02/2008
NAME OF PROVIDER OR SUPPLIER A DAY AWAY, ADULT DAY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6016 STAR POINT CT LAS VEGAS, NV 89081		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your facility on 10/02/2008. The census at the time of the survey was zero.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The facility has applied for a license as a six (6) clients Adult Day care Facility.</p> <p>One (1) mock resident file was reviewed and 3 employee files were reviewed.</p> <p>The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report.</p> <p>Please retain this copy for your records.</p>	U 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE